

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

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HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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7/1/2001

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COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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Attachment 4.19D page 6 (01-08)
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Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long
Term Care Facilities

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Healthcare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

M. Jane Kitchel

14. TITLE:

Secretary, Agency of Human Services

15. DATE SUBMITTED:

July 18, 2001

16. RETURN TO:

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Waterbury VT 05671-1201

FOR REGIONAL OFFICE USE ONLY

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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

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22. TITLE:

Associate Regional Administrator, DMSO

23. REMARKS:

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR
ESTABLISHING MEDICAID PAYMENT RATES
FOR LONG-TERM CARE FACILITIES

July 1, 2001

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quarterly for changes in each facility's case-mix score.
(See Addendum A §9.7.)

(f) The following cost limits shall be applied:

- (1) Nursing Care component - median cost for all facilities plus 15 percent.
- (2) Resident Care component - median cost for all facilities plus 5 percent.
- (3) Indirect component - median cost for all privately owned nursing facilities, except for special hospital-based facilities for which the limit is 137 percent of the median. (See Addendum A §§7.2-7.4)

(g) The Division shall by rule establish a method for determining the appropriated number of resident days to be used in calculating per diem rates and shall prescribe a minimum occupancy level (not lower than 90 percent of the certified beds in each facility) to be used for the purpose of calculating per diem costs and rates, which may be waived by rule for certain types of facilities, including, but not limited to, those with 20 or fewer beds or terminating facilities. (See Addendum A §5.7.)

(h) The Division shall by rule prescribe methods to be used for adjusting costs for projected economic conditions during the rate period. The Division may use inflation factors based on the DRI-NHMB and/or the NECPI or similar indexes. Different inflation factors are used to adjust difference rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual costs incurred by Vermont facilities for specific subcomponents of the relevant cost components. (See Addendum A §5.8) The indexes that are used for calculating the inflation factors are as follows:

- (1) Nursing Care - wages and salaries portion of DRI-NHMB and employee benefits portion of DRI-NHMB;
- (2) Resident Care - wages and salaries portion of DRI-NHMB, employee benefits portion of DRI-NHMB, food at home portion of the DRI-NHMB, utilities portion of the DRI-NHMB, and the NECPI-U (all items);
- (3) Indirect - wages and salaries portion of DRI-NHMB, employee benefits portion of DRI-NHMB, and the NECPI-U (all items);
- (4) Director of Nursing - wages and salaries portion of DRI-NHMB and employee benefits portion of DRI-NHMB;

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STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING



**METHODS, STANDARDS AND PRINCIPLES FOR
ESTABLISHING MEDICAID PAYMENT RATES
FOR LONG-TERM CARE FACILITIES**

JULY 2001
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1 GENERAL PROVISIONS

1.1 Purpose

The purpose of these rules is to implement state and federal reimbursement policy with respect to nursing facilities providing services to Medicaid eligible persons. The methods, standards, and principles of rate setting established herein reflect the objectives set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with the efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards, and meet the requirements of 42 U.S.C. §1396a(a)(13)(A).

1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

1.3 Authority

These rules are promulgated pursuant to 33 V.S.A. §§904(a) and 908(c) to meet the requirements of 33 V.S.A. Chapter 9, 42 U.S.C. §1396a(a)(13)(A).

1.4 General Description of the Rate Setting System

A prospective case-mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. A per diem rate is set for each facility

based on the historic allowable costs of that facility. The costs are divided into certain designated cost categories, some of which are subject to limits. The basis for reimbursement within the Nursing Care cost category is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The costs in some categories are adjusted to reflect economic trends and conditions, and the payment rate for each facility is based on the per diem costs for each category.

1.5 Requirements for Participation in Medicaid Program

(a) Nursing facilities must satisfy all of the following prerequisites in order to participate in the Medicaid program:

(1) be licensed by the Agency, pursuant to 33 V.S.A. §7103(b).

(2) be certified by the Secretary of Health and Human Services pursuant to 42 C.F.R. Part 442, Subpart C. and

(3) have executed a Provider Agreement with the Agency, as required by 42 C.F.R. Part 442, Subpart B.

(b) To the extent economically and operationally feasible, providers are encouraged, but not required, to be certified for participation in the Medicare program, pursuant to 42 C.F.R. §488.3.

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 1.5(a).

1.6 Responsibilities of Owners

The owner of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative shall in any way relieve the owner of a nursing facility from full responsibility for compliance with the requirements and standards of the Agency of Human Services.

1.7 Duties of the Owner

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The owner of a nursing facility, or a duly authorized representative shall:

- (a) Comply with the provisions of Subsections 1.5 and 1.6 setting forth the requirements for participation in the Medicaid Program.
- (b) Submit master file documents and cost reports in accordance with the provisions of Subsections 3.1, 3.2 and 3.3 of these rules.
- (c) Maintain adequate financial and statistical records and make them available at reasonable times for inspection by an authorized representative of the Division, the state, or the federal government.
- (d) Assure that an annual audit is performed in conformance with Generally Accepted Auditing Standards (GAAS).
- (e) Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

1.8 Powers and Duties of the Division and the Director

- (a) The Division shall establish and certify to the Department of Social Welfare per diem rates for payment to providers of nursing facility services on behalf of residents eligible for assistance under Title XIX of the Social Security Act.
- (b) The Division may request any nursing facility or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its function.
- (c) The Division may examine books and accounts of any nursing facility and related parties or organizations, subpoena witnesses and documents, administer oaths to witnesses and examine them on all matters over which the Division has jurisdiction.
- (d) From time to time, the Director may issue notices of practices and procedures employed by the Division in carrying out its functions under these rules.

(e) The Director shall prescribe the forms required by these rules and instructions for their completion.

(f) Copies of each notice of practice and procedure, form, or set of instructions shall be sent to each nursing facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor Final Orders of the Division which fail, in any one or more instances, to enforce the performance of any of the terms or conditions of these rules shall be construed as a waiver of the Division's future performance of the right. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

1.9 Powers and Duties of the Department of Aging and Disabilities' Division of Licensing and Protection as Regards Reimbursement

(a) The Division of Licensing and Protection of the Department of Aging and Disabilities shall receive from providers resident assessments on forms it specifies. The Department of Aging and Disabilities shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility based upon the Vermont version of 1992 RUGS-III (44 group version). This score will be used in the quarterly determination of the Nursing Care portion of the rate.

(b) The management of the resident assessment process used in the determination of case-mix scores shall be the duty of the Division of Licensing and Protection of the Department of Aging and Disabilities. Any disagreements between the facility's assessment of a resident and the assessment of that same resident by the audit staff of Licensing and Protection shall be resolved with the Division of Licensing and Protection and shall not involve the Division of Rate Setting. As the final rates are prospective and adjusted on

a quarterly basis to reflect the most current data, the Division of Rate Setting will not make retroactive rate adjustments as a result of audits or successfully appealed individual case-mix scores.

1.10 Computation of and Enlargement of Time; Filing and Service of Documents

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division or in the case of a document directed to be filed under this rule other than at the office of the Division, when it is received and stamped as received at the appropriate office. Filings with the Division may be made by telefacsimile (FAX), but the sender bears the risk of a communications failure from any cause. Filings shall be made by electronic data transfer at

such time as appropriate software and filing procedures are prescribed by the Division pursuant to subsection 1.8(d).

(e) Service of any document required to be served by this rule shall be made by delivering a copy of the document to the person or entity required to be served or to his or her representative or by sending a copy by prepaid first class mail to the official service address. Service by mail is complete upon mailing.

1.11 Representation in All Matters before the Division

(a) A facility may be represented in any matter under this rule by the owner (in the case of a corporation, partnership, trust, or other entity created by law, through a duly authorized agent), the nursing facility administrator, or by a licensed attorney or an independent public accountant.

(b) The provider shall file written notification of the name and address of its representative for each matter before the Division. Thereafter, on that matter, all correspondence from the Division will be addressed to that representative. The representative of a provider failing to so file shall not be entitled to notice or service of any document in connection with such matter, whether required to be made by the Division or any other person, but instead service shall be made directly on the provider.

1.12 Severability

If any part of these rules or their application is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of these rules are severable.

1.13 Effective Date

These rules are effective from January 29, 1992. (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, and August 1, 1999).

2 ACCOUNTING REQUIREMENTS

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2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules authorize specific variations in such principles.

(b) The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operational efficiency.

(c) The provider shall report on an accrual basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. In such a case, the provider's accounting process shall provide sufficient information to compile data to satisfy the accrued expenditure reporting requirements and to demonstrate the link between the accrual data reports and the non-accrual fiscal accounts. The provider shall retain all such documentation for audit purposes.

2.2 Procurement Standards

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle is a non-allowable cost.

2.3 Cost Allocation Plans and Changes in Accounting Principles

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) New facilities shall submit to the Division a proposed cost allocation plan within six months of the facility's opening.

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) No change in accounting principles or methods or basis of cost allocation may be made without prior written approval of the Division.

(d) Any application for a change in accounting principle or a change in the method or basis of cost allocation, which has an effect on the amount of allowable costs or the computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:

(1) the nature of the change;

(2) the reason for the change;

(3) the effect of the change on the per diem rate of payment; and

(4) the likely effect of the change on future rates of payment.

(e) The Division shall review each application and within 60 days of the receipt of the application approve, deny, or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

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(1) Nursing salaries and supplies - direct cost.

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary - resident days,

(6) Administrative and General - accumulated costs,

(7) Property and Related: Depreciation of Equipment - specific identification,

(8) Property and Related: All other property costs - square footage,

(9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs and multiplying by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost and multiplying by the total organization utility costs.

(j) All administrative and general costs, including home office and management company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, house-keeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way

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related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 33 V.S.A. §908(a), all documents and other materials filed with the Division are public information. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

3 FINANCIAL REPORTING

3.1 Master File

Providers shall submit the following documents for the purpose of establishing a Master file for each facility in the Vermont Medicaid program:

- (a) Copies of the articles of incorporation and bylaws,
- (b) Chart of accounts and procedures manual, including procurement standards established pursuant to Subsection 2.2(a),
- (c) Plant layout,
- (d) Terms of capital stock and bond issues,
- (e) Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements
- (f) Schedules for amortization of long-term debt and depreciation of plant assets,
- (g) Summary of accounting principles, cost allocation plans and step-down statistics used by the provider,
- (h) Appraisals,
- (i) and such other documents or information as the Director may require.

3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting

year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used *inter alia* as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this requirement may be waived for not-for-profit facilities).

(2) Most recently filed Medicare Cost Report (if a participant in the Medicare Program).

(3) Reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 Adequacy and Timeliness of Filing

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(a) An acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are *not* considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make an acceptable cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall receive no increase to its Medicaid rate until the first day of the calendar quarter after an acceptable cost report is filed.

3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

(1) The Division shall perform a uniform desk review on each cost report submitted.

(2) The uniform desk review is an analysis of the provider's cost report to determine the

adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review for the purpose of either settling the cost report without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Uniform desk reviews shall be completed within an average of 180 days after receipt of an acceptable cost report filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

(4) Unless the Division schedules an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

(b) On-site Audit

(1) The Division will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems in accordance with the relevant provisions of the *Medicare Intermediary Manual - Audits-Reimbursement Program Administration*. HCFA Publication 13-2 (HCFA-13).

(2) The Division will base its selection of a facility for an on-site audit on factors such as length of time since last audit, changes in facility ownership, management, or organizational structure, evidence or official complaints of financial irregularities questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

(3) The audit scope will be limited so as to avoid duplication of work performed by a independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(4) Upon completion of an audit, the Division shall review its draft findings and adjustments with the provider and issue a written summary report of such findings.

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(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2 and 15.3.

3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

4.1 Provider Reimbursement Manual and GAAP

In determining the allowability or reasonableness of costs or treatment of any reimbursement issue, not addressed in these rules, the Division shall apply the appropriate provisions of the Medicare Provider Reimbursement Manual (HCFA-15, formerly known as HIM-15). If neither these regulations nor HCFA-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles (GAAP). The Division reserves the right, consistent with applicable law, to determine the allowability and reasonableness of costs in any case not specifically covered in the sources referenced in this subsection.

4.2 General Cost Principles

For rate setting purposes, a cost must satisfy criteria, including but not limited to the following:

(a) The cost must be ordinary, reasonable, necessary, related to the care of residents, and actually incurred.

(b) The cost adheres to the prudent buyer principle.

(c) The cost is related to goods and/or services actually provided in the nursing facility.

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